PUBLIC HEALTH PAPERS **64**

HEALTH ECONOMICS

WORLD HEALTH ORGANIZATION
GENEVA

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Report on a WHO Interregional Seminar

This report is a summary of views expressed at the interregional seminar and does not necessarily represent the decisions or the stated policy of the World Health Organization.

WORLD HEALTH ORGANIZATION
GENEVA
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THE studies published in the Public Health Papers *series draw attention to modern trends and changing concepts in public health and are intended primarily to stimulate discussion and encourage planning. Some reflect purely personal opinions, others are of the symposium type, yet others are surveys of existing knowledge or practical approaches to tasks facing the public health or medical profession.*

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PREFACE

From its inception, the World Health Organization has been conscious of the importance of the economic manifestations of ill-health and disease, of the financial limitations that so often restrict the provision or procurement of adequate medical and health care, and of the difficulties besetting the assessment of benefits resulting from such care, in monetary terms or otherwise.

But since health is much too important for its measurement in monetary terms to be more than indicative for purposes of management and planning, the Organization had previously paid only intermittent attention to these matters in their own right, the financial or economic aspects of both health problems and of solutions proposed having been far more often dealt with incidentally rather than systematically.

The economics of providing health care is, however, a subject of growing importance and in 1973 the Organization arranged an interregional seminar to consider the subject in some detail. This publication is a summary of both the proceedings and some of the contributions to the seminar. It is hoped that it will help health administrators in the planning of health services and that it will interest students of medicine and of economics in the subject. A knowledge of health economics will enable those responsible for obtaining and deploying health service funds to make fuller and more effective use of the information and increasingly complex administrative and management techniques available in their endeavour to provide for the peoples they serve the highest attainable standard of physical, mental, and social wellbeing.

CHAPTER 1

GENERAL CONSIDERATIONS

INTRODUCTION

A WHO Interregional Seminar on Health Economics was held in Geneva from 2 to 16 July 1973. It was attended by 18 participants from all six WHO regions.[a]

Welcoming participants, Dr H. Mahler, then Assistant Director-General, recalled that, while the costs of health services were increasing, the information about them available to the public was of poor quality and lacking in objectivity. He expressed the hope that the Seminar would not only review the relevant concepts and facts but, in studying the economic approach to health services, also examine them in particular from the point of view of the benefit to the "consumer". Some of the questions of the moment to which clearer answers are sought are: what is a reasonable price to pay for health; what are the relations between consumers and health services; do consumers of health services receive value for money; and to what extent do consumers and/or producers benefit from health services? In that connexion, in most countries the health services are among the three largest "service" industries.

THE AIM OF HEALTH ECONOMICS

Economics applied to the health field, or "health economics" as it is now called, seeks *inter alia* to quantify over time the resources used in health service delivery, their organization and their financing; the efficiency with which resources are allocated and used for health purposes; and the effects of preventive, curative, and rehabilitative health services on individual and national productivity. The Seminar was unable to cover all the

[a] Participants are listed on pp. 43–44.

relevant topics, nor could it, under its terms of reference, confine its attention to the direct application of the principles of health economics to decision-making in health programming, health planning, and health service management; hence a number of distortions and omissions could not be avoided in the preparation of this report.

For instance, it should be borne in mind that health economics principles are abstract and remote from considerations of politics, power, and value conflicts, bargaining, and institutional reality. But where economic analysis is concerned, political and institutional reality must be explicitly taken into account. The analysis is "policy-oriented" if it is conducted from a certain viewpoint and within specific institutional constraints and opportunities. Policy-oriented analysis is useful for specific policy purposes, such as persuasion in favour of a certain course of action. Even where analysis shows that certain health service developments would be effective and well within the resources of the health sector,[a] further analysis is required to show whether, and how well, the health department could mobilize the required resources within its limited policy means, and both stimulate and maintain the required changes in the health sector. Economic evaluation techniques such as detailed cost/benefit analysis are most useful in a static and known decision environment. In reality, many policy options are only vaguely defined or have to be actively sought out. And the options to be considered are not only those within the organized health sector but also those of maintaining and promoting health through relevant actions in other sectors. Moreover, the implications of options over several years are often difficult and costly to forecast owing to lack of a reliable data base or the many uncertainties they entail. A detailed analysis of the kind discussed will therefore often not be feasible. Since decisions have nevertheless to be made, analysis will often have to consist of a crude, less costly, and iterative process of decision about priorities, programming, project design, and monitoring.

Consumers of health services were mainly discussed by the Seminar in terms of their health needs, the incentives they offer for service action, and the costs they incur. Little reference was made to the possibility of revealing or inferring consumers' preferences from their actual health behaviour, e.g., how much they currently spend on self- and folk-produced and on organized health services in relation to their expenditure on other goods and services. Consumer demand for health services reflects not only the need for health care but also other requirements including amenity, security, and certification. Calls for consumer or community participation gloss over the need for specifying, in each context, those modalities and facets of service decision-making and management in which the consumers and communities can most effectively take part, and for specifying also how the efficiency of these processes can be promoted over time.

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[a] For the purposes of this report the health sector includes all health services and service resources for which the health ministry or other government department has legal responsibility, either for direct production and delivery or for supervision and development.

One view is that a knowledge of the applications of economics to the administration of public health enables health planners to hold their own in discussions with other planners, with planning commissions, and with key government departments such as finance ministries. A knowledge of health economics also helps those responsible for the management of the considerable and increasing share of national resources being devoted to health services to meet the growing demand on the part of governments, legislatures, and the public for an explanation of the increasing *per capita* expenditure and spiralling costs of these services. It also helps them to ensure that the health services—and through them the consumers—obtain value for money and to limit in the process the freedom of the providers of care and of the international pharmaceutical industry to pursue their own exclusive interests within the health services. Health and socio-economic planning would be more easily linked if health planners were more aware of the economic impact of health services and other health-promoting action, though they should at all times bear in mind that, rather than an increase in national income, the aim of the health services must be better health—a social gain no less real for being difficult, if not impossible, to assess in monetary terms.

Another view is that health economics can bring to the health planning process a number of specialized techniques, such as statistical analysis, cost/benefit analysis, and systems analysis, combined with a certain detachment which, though not informed by the detailed knowledge and involvement of the medical practitioner, can give greater objectivity in the consideration of rival claims for priority. Among the economic concepts that health administrators should find useful are:

Opportunity cost, or the evaluation of what sacrifice is entailed—in terms of possible solutions to other problems—by the allocation of resources to the chosen activity.

The *margin*, or the amount by which a health programme should be increased or decreased in given circumstances (decisions for or against an entire programme being rare).

Quantity/quality conflict, or the distribution of health services where high quality will often mean fewer beneficiaries. (While what constitutes equality and fairness is basically a moral decision, economic efficiency and opportunity cost must also be taken into account.)

Cost/benefit analysis, or the organized consideration of the disadvantages and advantages of alternative policy options in terms of a common denominator, namely a common value unit, or *numéraire* (often a unit of money) and a common point of incidence, both in time and in terms of a system target (e.g., a nation, a region, the economy, or the health sector).

Where economic efficiency is concerned, the economist's view is that health services can be made either labour intensive or capital intensive according to the stage of development of the society they serve; that it is